

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0004499</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>													
<b>Facility Name:</b> <u>Bel-Wood Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.													
<b>Address:</b> <u>6701 W. Plank Road</u> <u>Peoria</u> <u>61604</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.													
<b>County:</b> <u>Peoria</u>															
<b>Telephone Number:</b> <u>(309) 697-4541</u> <b>Fax #</b> <u>(309) 697-6622</u>															
<b>IDPA ID Number:</b> <u>069-333-049-001</u>															
<b>Date of Initial License for Current Owners:</b> <u>11/30/68</u>															
<b>Type of Ownership:</b>															
<input type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>															
<input type="checkbox"/> Charitable Corp.															
<input type="checkbox"/> Trust															
<b>IRS Exemption Code</b> _____															
<input type="checkbox"/> <b>PROPRIETARY</b>															
<input type="checkbox"/> Individual															
<input type="checkbox"/> Partnership															
<input type="checkbox"/> Corporation															
<input type="checkbox"/> "Sub-S" Corp.															
<input type="checkbox"/> Limited Liability Co.															
<input type="checkbox"/> Trust															
<input type="checkbox"/> Other _____															
<input checked="" type="checkbox"/> <b>GOVERNMENTAL</b>															
<input type="checkbox"/> State															
<input checked="" type="checkbox"/> <b>County</b>															
<input type="checkbox"/> Other _____															
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Stephen Johnson</u> <b>Telephone Number:</b> <u>(309) 697-4541</u>		<table border="1"> <tr> <td rowspan="2"> <b>Officer or Administrator of Provider</b> </td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Stephen Johnson</u></td> </tr> <tr> <td rowspan="4"> <b>Paid Preparer</b> </td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) <u>see attached compilation report</u></td> </tr> <tr> <td colspan="2">           (Telephone) <u>( )</u> Fax # <u>( )</u> </td> </tr> <tr> <td colspan="2"> <b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630         </td> </tr> </table>		<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____	(Type or Print Name) <u>Stephen Johnson</u>	<b>Paid Preparer</b>	(Title) <u>Administrator</u>	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>see attached compilation report</u>	(Telephone) <u>( )</u> Fax # <u>( )</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630	
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____														
	(Type or Print Name) <u>Stephen Johnson</u>														
<b>Paid Preparer</b>	(Title) <u>Administrator</u>														
	(Signed) _____ (Date) _____														
	(Print Name and Title) _____														
	(Firm Name & Address) <u>see attached compilation report</u>														
(Telephone) <u>( )</u> Fax # <u>( )</u>															
<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630															

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home# 0004499 Report Period Beginning: 1/1/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>300</u>	Skilled (SNF)	<u>300</u>	<u>109,500</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>300</u>	TOTALS	<u>300</u>	<u>109,500</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,430</u>	<u>2,728</u>	<u>4,945</u>	<u>20,103</u>	8
9	SNF/PED					9
10	ICF	<u>57,579</u>	<u>18,310</u>	<u>290</u>	<u>76,179</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>70,009</u>	<u>21,038</u>	<u>5,235</u>	<u>96,282</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 87.93%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/30/68

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date                     NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 50and days of care provided 3,701Medicare Intermediary AdminaStar Federal, Inc.

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/03Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/03

Ending:

12/31/03

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	642,614	44,138		686,752		686,752		686,752			1
2	Food Purchase		416,814		416,814		416,814	(10,905)	405,909			2
3	Housekeeping	460,875	38,313	21,773	520,961		520,961		520,961			3
4	Laundry	162,975	27,118		190,093		190,093		190,093			4
5	Heat and Other Utilities			300,233	300,233		300,233		300,233			5
6	Maintenance	69,585	65,801	36,774	172,160		172,160	29,870	202,030			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	1,336,049	592,184	358,780	2,287,013		2,287,013	18,965	2,305,978			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			5,000	5,000		5,000		5,000			9
10	Nursing and Medical Records	4,294,937	353,691	1,221,224	5,869,852		5,869,852		5,869,852			10
10a	Therapy	36,935		201,535	238,470		238,470		238,470			10a
11	Activities	241,730	7,069	608	249,407		249,407	(1,638)	247,769			11
12	Social Services	74,471		3,735	78,206		78,206		78,206			12
13	Nurse Aide Training			2,500	2,500		2,500		2,500			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	4,648,073	360,760	1,434,602	6,443,435		6,443,435	(1,638)	6,441,797			16
	<b>C. General Administration</b>											
17	Administrative	84,300		52,928	137,228		137,228	(52,928)	84,300			17
18	Directors Fees							70,188	70,188			18
19	Professional Services			217,496	217,496		217,496	(38,854)	178,642			19
20	Dues, Fees, Subscriptions & Promotions			37,191	37,191		37,191	(11,157)	26,034			20
21	Clerical & General Office Expenses	366,462	5,937	54,355	426,754		426,754	306,753	733,507			21
22	Employee Benefits & Payroll Taxes			986,480	986,480		986,480	868,846	1,855,326			22
23	Inservice Training & Education			6,531	6,531		6,531		6,531			23
24	Travel and Seminar			9,202	9,202		9,202	(1,571)	7,631			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,040	38,040		38,040	47,041	85,081			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	450,762	5,937	1,402,223	1,858,922		1,858,922	1,188,318	3,047,240			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,434,884	958,881	3,195,605	10,589,370		10,589,370	1,205,645	11,795,015			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Bel-Wood Nursing Home

#0004499

Report Period Beginning:

1/1/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											30
	Depreciation			282,590	282,590		282,590		282,590			
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* loss on disposals			433	433		433	(433)				36
37	TOTAL Ownership			283,023	283,023		283,023	(433)	282,590			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,250	164,250		164,250		164,250			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			164,250	164,250		164,250		164,250			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,434,884	958,881	3,642,878	11,036,643		11,036,643	1,205,212	12,241,855			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**      A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
<b>NON-ALLOWABLE EXPENSES</b>				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(10,905)	2		4
5 Telephone, TV & Radio in Resident Rooms	(14,593)	21		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment	(7,516)	22		19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(11,157)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(3,642)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,813)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	1,253,025		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 1,253,025		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ 1,205,212		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Bel-Wood Nursing Home

ID# 0004499

Report Period Beginning: 1/1/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	patient activity	\$ (1,638)	11	1
2	out of state travel	(1,571)	24	2
3	loss on disposal of equipment	(433)	36	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,642)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bel-Wood Nursing Home# 0004499

Report Period Beginning:

1/1/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,905)	0	0	0	0	0	0	0	0	0	0	(10,905)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	29,870	0	0	0	0	0	0	0	0	0	29,870	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(10,905)</b>	<b>29,870</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>18,965</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,638)	0	0	0	0	0	0	0	0	0	0	(1,638)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,638)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,638)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(52,928)	0	0	0	0	0	0	0	0	0	(52,928)	17
18	Directors Fees	0	70,188	0	0	0	0	0	0	0	0	0	70,188	18
19	Professional Services	0	(38,854)	0	0	0	0	0	0	0	0	0	(38,854)	19
20	Fees, Subscriptions & Promotions	(11,157)	0	0	0	0	0	0	0	0	0	0	(11,157)	20
21	Clerical & General Office Expenses	(14,593)	321,346	0	0	0	0	0	0	0	0	0	306,753	21
22	Employee Benefits & Payroll Taxes	(7,516)	876,362	0	0	0	0	0	0	0	0	0	868,846	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,571)	0	0	0	0	0	0	0	0	0	0	(1,571)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	47,041	0	0	0	0	0	0	0	0	0	47,041	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(34,837)</b>	<b>1,223,155</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,188,318</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(47,380)</b>	<b>1,253,025</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,205,645</b>	<b>29</b>

## Summary B

12/31/03

[illegible]

Facility Name & ID Number Bel-Wood Nursing Home# 0004499

Report Period Beginning:

1/1/03

Ending:

12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 Facilities Management	\$	Peoria County	100.00%	\$ 29,870	\$ 29,870	1
2	V	17 Management Fee	52,928	Peoria County	100.00%		(52,928)	2
3	V	18 County Board		Peoria County	100.00%	70,188	70,188	3
4	V	19 Professional Services	137,879	Peoria County	100.00%	99,025	(38,854)	4
5	V	21 Clerical Services		Peoria County	100.00%	321,346	321,346	5
6	V	22 Employee Benefits	198,589	Peoria County	100.00%	444,165	245,576	6
7	V	26 Liability Insurance	38,040	Peoria County	100.00%	85,081	47,041	7
8	V	22 IMRF		Peoria County	100.00%	148,978	148,978	8
9	V	22 FICA		Peoria County	100.00%	481,808	481,808	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 427,436			\$ 1,680,461	\$ * 1,253,025	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home # 0004499 Report Period Beginning: 1/1/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bel-Wood Nursing Home# 0004499 Report Period Beginning:

1/1/03

Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Peoria County

Street Address

Rm 501, Peoria County Courthouse

City / State / Zip Code

Peoria, IL 61602

Phone Number

( 309 )672-6056

Fax Number

( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Facilities Management	Direct Allocation		\$	\$		\$ 29,870	1
2	18	County Board	per DMG-Maximus,					70,188	2
3	19	Professional Services	Inc. (see attached					99,025	3
4	21	Clerical Services	schedules)					321,346	4
5	22	Employee Benefits	(further detail available					444,165	5
6	26	Liability Insurance	upon request)					85,081	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 1,049,675	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related							\$		\$			9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related							\$		\$			14
15	TOTALS (line 9+line14)							\$		\$			15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ \_\_\_\_\_      Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)      SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Bel-Wood Nursing Home**# **0004499**Report Period Beginning: **1/1/03**Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2002 report.		\$	1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	3																									
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$      For      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1998</td><td>8</td></tr> <tr><td>1999</td><td>9</td></tr> <tr><td>2000</td><td>10</td></tr> <tr><td>2001</td><td>11</td></tr> <tr><td>2002</td><td>12</td></tr> </table>	1998	8	1999	9	2000	10	2001	11	2002	12	<table border="1"> <tr> <td></td> <td><b>FOR OHF USE ONLY</b></td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1998	8																											
1999	9																											
2000	10																											
2001	11																											
2002	12																											
	<b>FOR OHF USE ONLY</b>																											
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																										
14	PLUS APPEAL COST FROM LINE 5 \$	14																										
15	LESS REFUND FROM LINE 6 \$	15																										
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																										

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Bel-Wood Nursing Home COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0004499

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ _____</b>	<b>\$ _____</b>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,800
 B. General Construction Type:
 Exterior Brick
 Frame Steel
 Number of Stories 1

C. Does the Operating Entity?
 [X] (a) Own the Facility
 [ ] (b) Rent from a Related Organization.
 [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 [X] (a) Own the Equipment
 [ ] (b) Rent equipment from a Related Organization.
 [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

 E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 [ ] YES
 [X] NO
 If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:
 3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	8 acres	1848	\$ 100	1
2					2
3	TOTALS	#VALUE!		\$ 100	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/03

Ending:

12/31/03

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	300	1969	1969	\$ 3,123,273	\$ 62,465	50	\$ 62,465	\$	\$ 2,186,287
5		1975	1975	4,223	94	45	94		2,723
6		1986	1986	47,151	1,566	various	1,566		44,894
7									
8									
<b>Improvement Type**</b>									
9	Improvements	1978		10,851	271	40	271		7,072
10	Improvements	1979		43,777	9	20-25	9		43,777
11	Improvements	1980		115,619		20-25			115,619
12	Improvements	1983		968		15			968
13	Improvements	1984		22,787		various			22,787
14	Improvements	1985		512,902	25,244	various	25,244		497,015
15	Improvements	1986		48,090	2,405	20	2,405		42,687
16	Improvements	1987		23,252		various			23,252
17	Improvements	1988		132,642	7,156	various	7,156		108,846
18	Improvements	1989		176,637	9,525	various	9,525		135,374
19	Improvements	1990		194,031		various			194,031
20	Improvements	1991		1,058,535	51,696	various	51,696		659,089
21	Improvements	1992		192,921	10,299	various	10,299		122,572
22	Painting	1993		729		5			729
23	Driveway	1994		1,453	145	10	145		1,330
24	Improvements	1995		7,608	414	16-20	414		3,416
25	Building Improvements	1995		41,142	2,390	5-20	2,390		25,194
26	Resurface Driveway	1996		2,947	184	16	184		1,196
27	Activity Area Remodeling	1996		258	16	16	16		126
28	Draperies	1996		1,218	122	10	122		894
29	Resident Room Remodeling	1996		1,174	78	15	78		508
30	Resident Room Remodeling	1996		1,440	96	15	96		624
31	Telephone Wiring	1996		2,383	119	20	119		754
32	Draperies	1996		2,691	269	10	269		1,704
33	Resident Room Remodeling	1996		3,977	265	15	265		2,120
34	Resident Room Remodeling	1996		696	46	15	46		322
35	Faucets	1997		1,862	93	20	93		566
36	Replace Floor	1997		1,035	52	20	52		316

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/03

Ending:

12/31/03

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Motor	1997	\$ 1,022	\$ 102	10	\$ 102	\$	\$ 612		37
38	Remodeling	1997	1,923	96	20	96		637		38
39	Door Replacement	1997	4,957	248	20	248		1,695		39
40	Ceiling Tile	1997	1,488	99	15	99		668		40
41	Concrete Slabs	1997	825	41	20	41		270		41
42	Renovation of Study	1997	4,900	490	10	490		3,430		42
43	Sinks	1997	3,718	186	20	186		1,193		43
44	Plumbing	1997	2,397	96	25	96		616		44
45	Lights	1997	12,479	693	18	693		4,851		45
46	Compressor	1997	5,680	379	15	379		2,400		46
47	Wire	1997	337	17	20	17		105		47
48	Energy Management System	1998	717	72	5	72		716		48
49	Flourescent Lamps	1998	1,458	71	5	71		1,458		49
50	Fireplace	1998	946	47	20	47		259		50
51	Water Pressure Pump	1998	2,226	223	10	223		1,208		51
52	Bi-Fold Doors	1998	27,343	2,734	10	2,734		13,670		52
53	Sink System	1998	2,569	128	20	128		726		53
54	Handrails	1998	1,955	196	10	196		1,078		54
55	Water Softner	1998	34,106	2,842	12	2,842		15,157		55
56	Wire	1998	659	33	20	33		184		56
57	Roof Repair	1998	3,760	376	10	376		2,099		57
58	Draperies	1998	874	58	15	58		300		58
59	Borderwork	1998	840	56	15	56		317		59
60	Borders	1998	285	19	15	19		104		60
61	Covebase	1998	353	24	15	24		132		61
62	Covebase	1998	46	3	15	3		17		62
63	Wallpaper	1998	985	49	20	49		274		63
64	Wallpaper	1998	1,885	94	20	94		533		64
65	Wallpaper	1998	1,075	54	20	54		310		65
66	Wallpaper	1998	434	22	20	22		117		66
67	Roof Repairs	1998	3,467	347	10	347		1,735		67
68	Draperies	1998	1,872	125	15	125		625		68
69	Underground Storage Tank	1998	26,041	651	40	651		3,906		69
70	TOTAL (lines 4 thru 69)		\$ 5,931,894	\$ 185,690		\$ 185,690	\$	\$ 4,308,194		70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,931,894	\$ 185,690		\$ 185,690	\$	\$ 4,308,194	1
2	Energy management system modifications	1999	3,732	373	10	373		1,741	2
3	Curtains	1999	797	80	10	80		366	3
4	Roof Repairs	1999	1,254	84	15	84		378	4
5	Shelving, dish room	2000	1,500	75	20	75		281	5
6	Door relocation	2000	1,461	73	20	73		268	6
7	Roof Repairs	2000	3,552	237	15	237		849	7
8	Water Main #1	2000	3,178	127	25	127		445	8
9	Housing Assembly	2000	874	87	10	87		305	9
10	Sidewalk Replacement	2000	1,350	68	20	68		238	10
11	Draperies	2000	4,839	484	10	484		1,654	11
12	Water Main #2	2000	2,120	85	25	85		283	12
13	Draperies	2000	728	73	10	73		237	13
14	Door guards	2000	1,694	85	20	85		276	14
15	Door, magnetic lock	2000	4,062	203	20	203		643	15
16	Replacement glass	2001	2,971	149	20	149		434	16
17	Fire system	2001	496	62	8	62		176	17
18	Water heater replacement	2001	84,666	10,583	8	10,583		28,857	18
19	Drawer front machine	2001	1,690	113	15	113		311	19
20	Paint	2001	5,028	1,006	5	1,006		2,682	20
21	Roof sealant	2001	1,039	208	5	208		433	21
22	Windows	2002	59,439	2,972	20	2,972		3,715	22
23	Resident Alarm System	2002	43,538	2,177	20	2,177		2,358	23
24	Exit Device	2002	1,862	186	10	186		186	24
25	Egress Bars for doors	2002	2,630	263	10	263		285	25
26	Rooftop Unit Pilot Program Phse 1	2002	1,420	95	15	95		95	26
27	Construction Documents	2002	6,750	844	8	844		844	27
28	Control Wiring	2002	2,495	125	20	125		198	28
29	Roof Repairs	2002	1,642	109	15	109		191	29
30	Architect fees per IDPA review of 1999 cost report	1999	15,290	1,911	8	1,911		1,911	30
31	Exit Signs	2003	2,596	238	10	238		238	31
32	Air Cylinder - Drain	2003	1,049	70	10	70		70	32
33	Zone Motor & Bases	2003	4,211	140	10	140		140	33
34	TOTAL (lines 1 thru 33)		\$ 6,201,847	\$ 209,075		\$ 209,075	\$	\$ 4,359,282	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 6,201,847	\$ 209,075		\$ 209,075	\$	\$ 4,359,282	1
2 Construction Documentation	2003	12,854	402	8	402		402	2
3 Fence for Alzheimer Unit	2003	4,277	71	15	71		71	3
4 Parking lot overlay	2003	39,414	616	16	616		616	4
5 Water heater replacement	2003	52,500	875	15	875		875	5
6 Engineering	2003	3,700	77	8	77		77	6
7 Water main replacement	2003	80,810	269	25	269		269	7
8 Fire alarm panel replacement	2003	22,710	95	20	95		95	8
9 Reception Area Remodel	2003	2,904		20				9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 6,421,016	\$ 211,480		\$ 211,480	\$	\$ 4,361,687	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete

Facility Name &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning:

1/1/03

Ending:

12/31/03

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 706,463	\$ 62,841	\$ 62,841	\$	5 to 20	\$ 357,806	71
72	Current Year Purchases	41,234	1,169	1,169		8 to 20	1,169	72
73	Fully Depreciated Assets	687,119	5,350	5,350		5 to 20	687,119	73
74								74
75	TOTALS	\$ 1,434,816	\$ 69,360	\$ 69,360	\$		\$ 1,046,094	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	2001 Dodge Ram Truck	2000	\$ 13,998	\$ 1,750	\$ 1,750	\$	8	\$ 6,271	76
77	Maintenance	1989 Chevy Bus	1989	8,388				5	8,388	77
78	Business	Auto	1995	13,077				4	13,077	78
79	Resident	1997 Ford Eldorado	1997	42,701				4	42,701	79
80	TOTALS			\$ 78,164	\$ 1,750	\$ 1,750	\$		\$ 70,437	80

## E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,934,096	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 282,590	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 282,590	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,478,218	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

## G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2004 \$ \_\_\_\_\_

13. \_\_\_\_\_/2005 \$ \_\_\_\_\_

14. \_\_\_\_\_/2006 \$ \_\_\_\_\_

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input checked="" type="checkbox"/>  HOURS PER AIDE <u>n/a</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input checked="" type="checkbox"/>  HOURS PER AIDE <u>n/a</u>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 2,500	\$	\$ 2,500
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 2,500	\$	\$ 2,500
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,500		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12										
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 83,108	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 319,125 )	1,154,341		3
4	Supply Inventory (priced at cost )	70,402		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,307,851	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100		13
14	Buildings, at Historical Cost	6,205,826		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,512,980		16
17	Accumulated Depreciation (book methods)	(5,134,502)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,584,404	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,892,255	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 374,342	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	731,501		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Other Funds</u>	3,959,205		36
37	<u>Deferred Revenue</u>	58,289		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 5,123,337	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 5,123,337	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,231,082)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,892,255	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (863,435)	1
2	Restatements (describe):		2
3	adjustment to agree equity to general ledger		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (863,435)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(268,058)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) dif in method used in acctng for payroll	(88,485)	15
16	Other (describe) dif in method used for depreciation	(11,104)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (367,647)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,231,082)	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning: 1/1/03

Ending:

12/31/03

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,963,436	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,963,436	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	775,720	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,905	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 786,625	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	8,580	24
25	Interest and Other Investment Income***	83	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,663	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>see attached summary</u>	9,861	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,861	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,768,585	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,287,013	31
32	Health Care	6,443,435	32
33	General Administration	1,858,922	33
<b>B. Capital Expense</b>			
34	Ownership	283,023	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	164,250	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,036,643	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(268,058)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (268,058)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Bel-Wood Nursing Home

# 0004499

Report Period Beginning: 1/1/03

Ending:

12/31/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,484	18,420	401,485	21.80	3
4	Licensed Practical Nurses	48,130	56,773	1,022,481	18.01	4
5	Nurse Aides & Orderlies	189,054	222,348	2,838,398	12.77	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,483	2,225	56,140	25.23	9
10	Activity Assistants	9,194	11,202	185,590	16.57	10
11	Social Service Workers	3,509	4,300	74,471	17.32	11
12	Dietician					12
13	Food Service Supervisor	1,791	2,268	49,213	21.70	13
14	Head Cook	1,838	2,175	33,872	15.57	14
15	Cook Helpers/Assistants	41,979	48,798	559,529	11.47	15
16	Dishwashers					16
17	Maintenance Workers	4,979	5,627	69,585	12.37	17
18	Housekeepers	35,642	42,448	460,875	10.86	18
19	Laundry	10,885	14,036	162,975	11.61	19
20	Administrator	1,932	2,080	84,300	40.53	20
21	Assistant Administrator					21
22	Other Administrative	1,806	2,114	58,005	27.44	22
23	Office Manager					23
24	Clerical	19,436	23,807	308,457	12.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	1,728	2,158	36,935	17.12	30
31	Medical Records	1,881	2,303	32,573	14.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	389,751	463,082	\$ 6,434,884 *	\$ 13.90	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		5,000	L9-C3	36
37	Medical Records Consultant		1,920	L10-C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,400	L10-C3	39
40	Physical Therapy Consultant	4,115	122,345	L10a-C3	40
41	Occupational Therapy Consultant	4,130	48,694	L10a-C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	740	15,806	L10a-C3	43
44	Activity Consultant	14	608	L11-C3	44
45	Social Service Consultant	71	3,735	L12-C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	9,070	\$ 200,508		49

## C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,790	\$ 65,010	L10-C3	50
51	Licensed Practical Nurses	22,289	745,576	L10-C3	51
52	Nurse Aides	21,243	384,119	L10-C3	52
53	TOTAL (lines 50 - 52)	45,322	\$ 1,194,705		53

SEE ACCOUNTANTS' COMPILATION REPORT

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount			
Stephen Johnson	Administrator	0	\$ 84,300	Workers' Compensation Insurance		\$ 27,515	IDPH License Fee	\$			
				Unemployment Compensation Insurance		(6,197)	Advertising; Employee Recruitment	13,122			
				FICA Taxes		481,808	Health Care Worker Background Check				
				Employee Health Insurance		1,201,812	(Indicate # of checks performed _____)				
				Employee Meals			County Nursing Home Association	2,500			
				Illinois Municipal Retirement Fund (IMRF)*		148,978	Notary Public Association	45			
				Background Checks		1,000	Illinois Medical Directors Association	70			
				EAP program		270	Sam's Club	60			
				TB tests		140	Dept. of Professional Regulation	100			
							See attached Schedule	21,294			
							Less: Public Relations Expense	(			
							Non-allowable advertising	(11,157)			
							Yellow page advertising	(			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,300				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,034			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)							
Description			Amount								
Peoria County Management Fees			\$ 52,928								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 52,928								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
Peoria County	Data Processing		\$ 137,879			\$	Out-of-State Travel	\$			
Clifton Gunderson LLP	Accounting		22,500								
Duane Morris	Legal		54,960								
Enloe	Data Processing		1,800				In-State Travel				
Med line	Data Processing		328				In state seminar travel	920			
Peoria County Recorder of Deeds	Legal		29								
							Seminar Expense				
							See attached schedule	6,711			
							Entertainment Expense	(			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 217,496	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 7,631			

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p><b>Facility Name &amp; ID Number</b>    <u>Bel-Wood Nursing Home</u></p> <p><b>XX. GENERAL INFORMATION:</b></p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union?    <u>Yes</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report?    <u>Yes</u> If YES, give association name and amount.    <u>See attached schedule</u></p> <p>(3) Did the nursing home make political contributions or payments to a political organization?    <u>No</u>    If YES, have these costs been properly adjusted out of the cost report?    _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?    <u>No</u>    If YES, what is the capacity?    _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases?    <u>Yes</u> What was the average life used for new equipment added during this period?    <u>11.4</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.    \$ <u>71,271</u>    Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?    <u>Yes</u>    If NO, attach a complete explanation.    _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement?    <u>No</u> If YES, give effective date of lease.    _____</p> <p>(9) Are you presently operating under a sublease agreement?    _____ YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?    YES _____ NO <u>X</u>    If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.    \$ <u>164,250</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?    <u>No</u>    If YES, attach an explanation of the allocation.    _____</p> <p style="text-align: center;"><b>SEE ACCOUNTANTS' COMPILATION REPORT</b></p>	<p style="text-align: center;"><b>STATE OF ILLINOIS</b></p> <p>#    <u>0004499</u>    Report Period Beginning:    <u>1/1/03</u>    Ending:    <u>12/31/03</u></p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?    <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u>    For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V.    \$ <u>None</u>    Has any meal income been offset against related costs?    <u>Yes</u>    Indicate the amount.    \$ <u>10,905</u></p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel?    <u>Yes</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents?    <u>No</u>    If YES, please indicate the amount of income earned from such a program during this reporting period.    \$ _____ c. What percent of all travel expense relates to transportation of nurses and patients?    <u>0</u> d. Have vehicle usage logs been maintained?    <u>Yes</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use?    <u>Yes</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?    <u>n/a</u> <b>g. Does the facility transport residents to and from day training?    <u>No</u></b> <b>Indicate the amount of income earned from providing such transportation during this reporting period.    \$ <u>n/a</u></b></p> <p>(17) Has an audit been performed by an independent certified public accounting firm?    <u>Yes</u> Firm Name:    <u>Clifton Gunderson LLP</u>    The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?    <u>No</u>    If no, please explain.    <u>Audit is currently in progress</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?    <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?    <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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